SMART Medication Safety Agenda

Prescribing

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The Community Pharmacy Incident Reporting (CPhIR) program is designed for you to report and analyze medication incidents that occurred in your pharmacy. You can learn about medication incidents that have occurred in other pharmacies through the use of the SMART Medication Safety Agenda.

The **SMART** (**S**pecific, **M**easurable, **A**ttainable, **R**elevant and **T**ime-based) Medication Safety Agenda consists of actual medication incidents that were anonymously reported to the CPhIR program. Potential contributing factors and recommendations are provided to you and your staff to initiate discussion and encourage collaboration in continuous quality improvement. By putting together an assessment or action plan, and monitoring its progress, the SMART Medication Safety Agenda may help reduce the risk of similar medication incidents from occurring at your pharmacy.

How to Use the SMART Medication Safety Agenda

1. Convene a meeting for your pharmacy team to discuss each medication incident presented (p. 2).
2. Review each medication incident to see if similar incidents have occurred or have the potential to occur at your pharmacy.
3. Discuss the potential contributing factors and recommendations provided.
4. Document your team's assessment or action plan to address similar medication incidents that may occur or may have occurred at your pharmacy (Table 2).
5. Evaluate the effectiveness and feasibility (Table 1) of your team's suggested solutions or action plan.
6. Monitor the progress of your team's assessment or action plan.
7. Enter the date of completion of your team's assessment or action plan (Table 2).

Table 1.
Effectiveness and Feasibility

Effectiveness:

Suggested solution(s) or action plan should be system-based, i.e. shifting a focus from "*what we need to do …*" to "*what we can do to our environment to work around us.*"

1. **High Leverage – most effective**
   - Forcing function and constraints
   - Automation and computerization
2. **Medium Leverage – intermediate effectiveness**
   - Simplification and standardization
   - Reminders, checklists, and double checks
3. **Low leverage – least effective**
   - Rules and policies
   - Education and information

Feasibility:

Suggested solution(s) or action plan should be feasible or achievable within your pharmacy, both from the perspectives of human resources and physical environment.

1. Feasible immediately
2. Feasible in 6 to 12 months
3. Feasible only if other resources and support are available

Institute for Safe Medication Practices Canada
Institut pour la sécurité des médicaments aux patients du Canada

CMIRPS �֍ SCDPIM
Canadian Medication Incident Reporting and Prevention System
Système canadien de déclaration et de prévention des incidents médicamenteux

COMPASS
Community Pharmacy Professionals Advancing Safety in Saskatchewan

Si Safety. Improvement. Quality.

Prescribing

Drug Interaction

A patient was on Eliquis® (apixaban) and Aspirin® (acetylsalicylic acid) 81 mg, and was then prescribed naproxen for two weeks. The patient experienced a nose bleed that wouldn't stop and was admitted to an acute care hospital for treatment. The drug interaction between Eliquis®, Aspirin® and naproxen (i.e., an increased risk of bleeding) was not communicated to the doctor or staff at the nursing home to prompt additional patient monitoring.

POTENTIAL CONTRIBUTING FACTOR:
- Drug interactions are possible for almost all medications, and the risk of an interaction increases with an increase in the number of medications. The prescriber's computer system did not alert the user to the drug interaction at the point of prescribing, therefore it was assumed that the pharmacist would inform them of any relevant medication-related information.

RECOMMENDATIONS:
- Ensure that a standardized system is in place to notify prescribers of potentially serious drug interactions. Ideally, this notification would include therapeutic alternatives or appropriate actions to manage potential risks.[1]
- Consider a standardized system that includes follow up with patients to monitor for potential adverse events due to serious drug interactions.

Illegible Writing

A family physician contacted the pharmacy to determine how a mutual patient received amitriptyline instead of the intended azathioprine. The pharmacist checked the original prescription and found that the specialist's handwriting was almost illegible. Unfortunately, the specialist had not been contacted to clarify the medication prior to dispensing it.

POTENTIAL CONTRIBUTING FACTOR:
- A poorly handwritten prescription was misinterpreted by a member of the pharmacy team, and a double check process was lacking (i.e., with another member of the pharmacy team and/or the prescriber).

RECOMMENDATIONS:
- Establish a policy and procedure for independent double checks, to be applied selectively to the medication use processes that warrant their application (i.e., high-alert medications, illegible prescriptions).[2]
- Ensure that a standardized system is in place to communicate with prescribers regarding prescription clarification, clinical decision-making, etc.

Table 2.
Assessment / Action Plan

Effectiveness:

- ☐ Forcing function and constraints
- ☐ Automation and computerization
- ☐ Simplification and standardization
- ☐ Reminders, checklists and double checks
- ☐ Rules and policies
- ☐ Education and information

Feasibility:

- ☐ Feasible immediately
- ☐ Feasible in 6 to 12 months
- ☐ Feasible only if other resources and support are available

Progress Notes

Date of Completion:

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1 ISMP Canada. Preventable Death Highlights the Need for Improved Management of Known Drug Interactions. ISMP Canada Safety Bulletin. 2014 May;14(5):1-7. Available from: http://ismp-canada.org/download/safetyBulletins/2014/ISMPCSB2014-5_KnownDrugInteractions.pdf
2 ISMP Canada. Lowering the Risk of Medication Errors: Independent Double Checks. ISMP Canada Safety Bulletin. 2005 Jun;5(1):1-2. Available from: https://www.ismp-canada.org/download/safetyBulletins/ISMPCSB2005-01.pdf